Family Planning Effort Index
Ibadan, Ilorin, Abuja, and Kaduna
Nigeria 2011

Introduction
Nigeria has a current population of 152 million with a growth rate of 3.2%, a Contraceptive Prevalence Rate (CPR) of 15.4 and a Total Fertility Rate (TFR) of 5.7. Nigeria plays an important role in the socio-political context of West Africa, since it constitutes 50.2% of the total population of the region (PRB 2009, DHS 2008). In response to the pattern of high growth rates, the National Policy on Population for Sustainable Development was launched in 2005. The policy recognized that population factors, social and economic development, and environmental issues are irrevocably interconnected and addressing them are critical to the achievement of sustainable development in Nigeria.

The Nigerian population policy sets specific targets aimed at addressing high rates of population growth including a reduction in the annual national growth rate to 2% or lower by 2015, a reduction in the TFR of at least 0.6 children per woman every five years, and an increase in CPR of at least 2% points per year. However, Nigeria still has a 20% unmet need for family planning (NPC and ICF Macro, 2009).

Family Planning was included in the fifth Millennium Development Goal (MDG) as an indicator for tracking progress of improving maternal health. This concept of integrating family planning with maternal health services is the same approach that the Nigerian Ministry of Health is utilizing with messages related to family planning highlighting the links between utilization and reduced maternal mortality. However, continuing low levels of CPR and high levels of maternal mortality highlight the importance of an increased emphasis on family planning both within the context of maternal health and other health and social benefits. This will take a commitment from government on all levels to ensure that family planning services and information are readily available to all people regardless of where they live, their gender and social status.

Urban Reproductive Health
Many countries are experiencing rapid growth in their urban populations and there is growing evidence to support the need for family planning programs to be directly targeted toward the urban poor. Research shows that the urban poor have higher fertility and lower contraceptive use than the non-poor urban population and often the rural population as well (Ezeh 2010, Montgomery 2009, Futures Institute analysis 2011). This trend of urbanization is particularly visible in Nigeria where there are more than 10 cities with populations of over a million people (Alkali 2005).

In an effort to address these urban inequalities, the Bill and Melinda Gates Foundation is supporting Urban Reproductive Health Initiatives in Nigeria, India, Kenya, and Senegal. Futures Institute is implementing advocacy activities to support these programs in all four countries.

The Nigerian Urban Reproductive Health Initiative (NURHI) is being implemented by the Johns Hopkins Bloomberg School of Public Health Center for Communication Programs. NURHI is currently being
implemented in the four Nigerian cities of Abuja, Ibadan, Ilorin, and Kaduna and will expand to two additional cities, Benin and Zaria.

Futures Institute is partnered with the Association for Reproductive and Family Health (ARFH) to implement advocacy activities and support NURHI with policy analysis and advocacy activities geared toward building leadership support for urban reproductive health. This paper provides baseline family planning effort information for the four current NURHI cities: Abuja, Ibadan, Ilorin and Kaduna.

**Description of Project Sites**

Nigeria operates a federal system through three tiers of government, federal (national), state, and local. The local government, which is administrated by geographical divisions known as Local Government Areas (LGA), is the closest to the people at the grassroots level. Typically, more than one LGA makes up a city, so the information reported in this paper was collected from 2 LGAs in Abuja, 5 in Ibadan, 5 in Ilorin, and 3 in Kaduna. The results for each city reported below combine the LGAs into a city level estimate. Figure 1 shows city locations, and a brief description of the project sites providing data from the 2008 NDHS is presented below.

**Ibadan:** Ibadan is the administrative capital of Oyo state, located in south west Nigeria. It is the largest city in West Africa and second to Cairo in Africa. The current CPR in Oyo state is 9.7(any modern method) and the TFR is 5.0.

**Ilorin:** Ilorin is the administrative capital of Kwara State, located in Nigeria’s north central geopolitical zone. In the last 8 years under the present dispersion of governance, Ilorin has witnessed positive changes in development efforts. The current CPR in Kwara is 16.5 and the TFR is 4.5.

**Abuja:** Abuja is the capital of Nigeria and the federal seat of power. Following the adoption of Abuja as the new capital city, the city has experienced a high influx of people, which has resulted in the emergence of unplanned settlements situated on the outskirts of the city. The current CPR in Abuja is 20.8 and the TFR is 4.0.

**Kaduna:** Kaduna is the administrative capital of Kaduna state located North West Nigeria. The state is multi-religion; the south is dominated by Christianity and the north by Islam. The state has witnessed a number of ethnic and religious conflicts in the last decade. The CPR of Kaduna is 9.6 and the TFR is 6.3.

**Family Planning Effort Index**

The Family Planning Effort Index (FPE) has been widely applied across countries over the past 30 years and the results have been used to set country priorities, measure progress, diagnose program
weaknesses at the national level, identify where programs are and are not doing well, and to strategically direct advocacy efforts (Ross and Smith, 2010).

The methodology for the FPE involves asking local family planning experts to rate the national family planning program in terms of specific efforts along four main components: policies, services, record-keeping and evaluation, and access to family planning methods. The FPE uses a likert scale from 1 to 10, with 1 representing non-existing or weak effort, and 10 a very strong effort. Respondents are asked to leave blank any questions that fall outside their area of expertise. The FPE index has been used primarily to assess national efforts, but there have been applications to provincial level efforts, in Vietnam and Egypt.

The FPE questionnaire that was used in the four Nigerian cities in 2011 maintained the traditional format of the FPE, but modified the structure and some questions to be applicable to the decentralized LGA level. The sections on policy and service delivery were asked twice, once with respondents being asked to respond related to the national level effort and once to the LGA level effort. For the second two sections the respondents were asked to respond only in reference to the LGA level effort.

Starting in 2004 the FPE three additional categories were added to the questionnaire and they were all included in the 2011 Nigerian survey. The new categories include:

- Positive and negative influences on the family planning program
- Current justifications for family planning programs
- Particular program emphasis on population subgroups

The Project Implementation (PI) team comprising of Futures Institute (FI), ARFH and NURHI, jointly modified the FPE questionnaire and identified relevant experts to be interviewed. A total of 30 stakeholders each were expected to be reached in Ibadan and Ilorin, 22 in Kaduna and 16 in Abuja, making a total of 98 stakeholders, but not all the stakeholders were available in each LGA. The tool was pretested in one of the project sites for gaps and the estimated burden of time required for completion.

Seventy percent of the total tools administered were retrieved from the stakeholders for analysis. Seventy-two surveys were completed by LGA representatives, service providers, and local staff from family planning NGOs. The number of total surveys completed in each city was: Ilorin, 21, Ibadan, 19, Abuja, 18, and Kaduna, 14. For each item, the mean of the responses is presented as a percentage of the maximum potential score of 100 percent.

The combined FPE results for the four cities, along with the overall average for each category, are presented in Figure 2. As shown, Ilorin’s scores are consistently highest and Kaduna the lowest in all the categories.
Results by category are presented in the following sections.

Policy and Stage Setting

Average national policy scores for Ilorin, Ibadan, Abuja and Kaduna were, 66%, 47%, 54% and 46%, respectively. Ilorin scored the highest in 10 of the 12 questions, while Kaduna scored the lowest in seven of the 12 questions. Scores for each of the questions in the policy section are presented in Figure 3.

There was a lot of variation in the scores related to policy but the general pattern between the questions was similar for all four cities. Overall, Ilorin scored national level policy effort the highest. In all cities existence of pro-poor policies received a low score. The current lack of availability of contraceptive commodities is reflected in low scores related to funding.

Respondents reported the freedom to advertise contraceptives as the strongest policy item, which had an average score of 70% across the cities. Enforcement of women’s legal age of marriage of 18 had the lowest reported effort level, with an average score of 35%.
The average city policy scores for Ilorin, Ibadan, Abuja and Kaduna were, 59%, 48%, 53% and 39%, respectively. Responses related to city level effort, shown in Figure 4, follow the same general pattern as the scores related to national level effort, with Ilorin scoring highest in six of the categories. Abuja scored highest in three categories: favorable statements by leaders, seniority in leadership and enforcement of age of marriage policy. Kaduna scored the lowest in all but one item.

Respondents scored the seniority of the LGA leadership with an overall average effort of 70% which was the highest reported item. Enforcement of women’s legal marriage age of 18 scored at an effort of 34%, the lowest scoring item in the LGA policy question set.

Perceived national level effort showed greater inter-city variation than city level effort. Seven (60%) of the scores varied by 25% or higher from the highest to the lowest, with the maximum variation for the government’s allocation of resources for procuring family planning commodities, at 38%. For that category, Ilorin scored 73% and Ibadan scored 35% (Figure 3). At the city level, there were fewer items
with large variations in scores; four of the scores varied by 25% or higher, with adequate distribution of family planning commodities by the contraceptive logistics management system (CLMS) varying by 34%. For that item, Ilorin reported 74% and Kaduna reported 40%.

Respondents rated effort on the part of other ministries and public agencies to provide assistance with family planning activities (multi-sector Involvement) with an average score of 64%, the second highest score (only asked related to the national level), while support for private sector involvement was rated as 58% nationally and 53% at the city level.

In general, there was more reported effort on the national level to target funding to specific family planning commodities, with average scores of 49% nationally and 36% locally.

Additionally, both national and city scores show very low perceived effort toward enforcement of the legal age of marriage of 18 for women.

**Service and Service Related Activities**
National and city level service and service related activity scores mirrored each other almost exactly, as shown in Figures 5 and 6. Ilorin received the highest scores for all questions, and Kaduna had the lowest for all but three items. Ibadan scored the lowest for home visits, mass media and IEC (coverage of informational materials). Average national scores for Ilorin, Ibadan, Abuja and Kaduna were, 67%, 49%, 46% and 39%, respectively. Average city scores were 64%, 45%, 47% and 39%, respectively.
Respondents rated the national level effort by the private sector as the highest rated item nationally with an average score of 66% across all four cities. At the city level, respondents rated the effectiveness of program personnel as the highest item with an average of 61%. Coverage for home visits by workers trained to talk to women about family planning received very low effort scores both nationally and locally with average scores of 35% for both. Assessment of the logistics system that handles stocking contraceptive supplies and related equipment at all service points also received low scores at both national and city levels, 42% and 43%, respectively. Scores for social marketing were clustered together at around 60% of total effort nationally but had more variation locally.
Record Keeping and Evaluation
This section of the FPE seeks to assess the extent to which systems for client recordkeeping, clinic reporting and feedback of results are adequate in the city (record keeping), extent to which program statistics, surveys, and small studies are used by specialized LGA staff to report on program operations and measure progress (evaluation), extent to which program managers use research and evaluation findings to improve the program in ways suggested by findings (data for decision making), and the extent to which information is shared or spread from one LGA to another.

Responses for record keeping and evaluation showed an average score across the cities of 55%. Figure 7 provides individual city results. Ilorin’s results put it at the top for all items measured in this category. Ilorin’s average score was 68% (range: 62% for evaluation to 79% for record keeping), with the remaining cities scoring an average of 51% (Ibadan), 59% (Abuja) and 43% (Kaduna). Kaduna scored the lowest in all categories, with a range of 39% to 50%.

Availability and Accessibility of Methods
Quality family planning services include access to an uninterrupted supply of short and long-acting contraceptive methods. The 2011 FPE collected responders’ perceptions of ease of access to methods (Access) and the supply system’s ability to avoid stockouts and interruptions in supply while guaranteeing reliable flow at local levels (Supply) for eight methods, including IUDs, pills, injectables, female and male sterilization, condoms, implants, and emergency contraception. Results are summarized by access and supply, as shown in Figure 8.
Respondents report that the population has the easiest access to condoms, which had an average score of 75%, followed by pills, injectables, IUD, emergency contraception, implants, female sterilization, and male sterilization. Responses for the supply system mirror the access responses almost exactly with the scores for the methods falling in the exact same order. This reflects the inherent relationship between the two indicators, women only have access to the methods that are available through the supply system.

Reliable supply of contraceptives in Nigeria is of considerable concern, and this is reflected in the inter-city variation in the supply responses. The largest inter-city variation was 42%, for IUDs. Respondents report their confidence in the supply system for IUDs in Ilorin at 77% of full effort, but at only 35% in Kaduna. Pills follow a similar pattern, with a variation of 33%. For pills, Ilorin’s average score reached 78% while Kaduna’s was 45%. Injectable contraceptives had the third-highest inter-city variation of the supply variables, of 27%. Two access indicators showed lower but still high levels of variation in two methods, condoms and pills, which had a 25% and 26% variation between cities, respectively.

Methods that did not show high variation for both access and reliability of supply were male and female sterilization, which varied from 5% to 13%, reflecting a confluence of low popularity of the method combined with its low availability.

Table 1 presents the access and supply data for the 2011 FPE along with the country-level results for Nigeria from the 2009 FPE conducted globally by the Futures Group Health Policy Initiative (HPI). The 2011 data comes from the four cities and does not represent country-level results; however, it is clear by the data that Ilorin has consistently higher responses than both the 2009 and 2011 data, raising the current average for most variables.

<table>
<thead>
<tr>
<th>Method</th>
<th>2009 FPE (%)</th>
<th>2011 FPE (%)</th>
<th>2011 Ilorin Only (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>ACCESS</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>IUD</td>
<td>35</td>
<td>58</td>
<td>74</td>
</tr>
<tr>
<td>Pills</td>
<td>44</td>
<td>68</td>
<td>81</td>
</tr>
<tr>
<td>Injectables</td>
<td>41</td>
<td>66</td>
<td>76</td>
</tr>
<tr>
<td>Male Sterilization</td>
<td>18</td>
<td>29</td>
<td>27</td>
</tr>
<tr>
<td>Female Sterilization</td>
<td>15</td>
<td>23</td>
<td>24</td>
</tr>
<tr>
<td>Condoms</td>
<td>66</td>
<td>75</td>
<td>85</td>
</tr>
<tr>
<td><strong>SUPPLY</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>IUD</td>
<td>36</td>
<td>54</td>
<td>77</td>
</tr>
<tr>
<td>Pills</td>
<td>45</td>
<td>62</td>
<td>79</td>
</tr>
<tr>
<td>Injectables</td>
<td>43</td>
<td>62</td>
<td>77</td>
</tr>
<tr>
<td>Male Sterilization</td>
<td>17</td>
<td>27</td>
<td>29</td>
</tr>
<tr>
<td>Female Sterilization</td>
<td>15</td>
<td>21</td>
<td>21</td>
</tr>
<tr>
<td>Condoms</td>
<td>61</td>
<td>73</td>
<td>79</td>
</tr>
</tbody>
</table>

Table 1. Comparison of 2011 FPE results for Access and Supply with previous 2009 country-level results for Nigeria from Futures Group Health Policy Initiative raw data.
Influences on Family Planning Programs

Respondents were asked about how changes in the country’s family planning environment affect the family planning program. This question set scored items on a scale of -5 to +5, with -5 showing a large negative impact on family planning and +5 a large positive impact.

As shown in Figure 11, responders for Ibadan, Abuja and Kaduna perceive all changes measured as having a positive influence on their programs, especially the integration of family planning with reproductive health services and other health services. The bundling of family planning with HIV/AIDS programs was also perceived as having a positive effect. This is consistent with the overall program strategy of not focusing on family planning alone, but integrating it into maternal health services. Ilorin was the one exception to this pattern, as responders rated the changes in donor and government funding as negative influences on their programs. Also, in general, government and donor funding, and changes in government support have less influence on the program than the decentralization and integration variables.

Family Planning Program Justifications

The FPE also asked respondents about the current justifications of the family planning program. Respondents rated the following nine items on a scale of 1 to 10, with 1 meaning it had negligible importance and 10 meaning great importance.

- Reduce Population Growth
- Enhance Economic Development
- Avoid Unintended Pregnancy
- Improve Women’s Health
- Improve Child Health
- Reduce Unmarried Adolescent Child Bearing
- Reduce Unmet Need
- Meet Fertility Intentions
- Achieve Reproductive Rights of Women

Figure 11. Reported Effect of Influences on FP Programs in Ibadan, Abuja and Kaduna, Nigeria, 2011 FPE.
Table 2 provides the two highest and lowest rated justifications for each city. There were similarities in the responses; Ilorin, Abuja and Kaduna reported improving women’s health and improving children’s health as the two most important justifications, while responses for Ibadan rated helping women achieve their reproductive rights and meeting fertility intentions as the most important. The average across the cities ranked the three top most important justifications as improving women’s health first (most important overall), followed by improving children’s health and then helping women achieve their reproductive rights. The three least important justifications across the cities were reducing population growth (least important overall), followed by enhancing economic development and then reducing unmet need for contraceptives.

<table>
<thead>
<tr>
<th>Project sites</th>
<th>Highest Justification</th>
<th>Lowest Justification</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ilorin</td>
<td>Improve women’s health</td>
<td>Reduce unmet need for contraceptive services</td>
</tr>
<tr>
<td></td>
<td>Improve child health</td>
<td>Reduce rate of population growth</td>
</tr>
<tr>
<td>Ibadan</td>
<td>Help women achieve their RR</td>
<td>Reduce rate of population growth</td>
</tr>
<tr>
<td></td>
<td>Meet fertility intentions</td>
<td>Enhance economic development</td>
</tr>
<tr>
<td>Abuja</td>
<td>Improve women’s health</td>
<td>Enhance economic development</td>
</tr>
<tr>
<td></td>
<td>Improve child health</td>
<td>Reduce unmet need for contraceptive services</td>
</tr>
<tr>
<td>Kaduna</td>
<td>Improve women’s health</td>
<td>Reduce rate of population growth</td>
</tr>
<tr>
<td></td>
<td>Improve child health</td>
<td>Enhance economic development</td>
</tr>
</tbody>
</table>

**Table 2. Respondent Ratings of Highest and Lowest Justifications for Family Planning Programs, 2011 FPE.**

### Emphasis on Special Populations

Special populations were rated from those given the most emphasis to those given the least emphasis in each family planning program. Table 3 provides the two most emphasized and the two least emphasized population groups for each city. According to the respondents, urban populations, postpartum women and HIV+ populations receive the most emphasis, and overall averages across the cities place urban populations as the most important group, with postpartum women and HIV+ populations ranked as the second most important together.

The lowest emphasized populations include newly married women wanting to delay their first child, followed by single women and rural populations.

<table>
<thead>
<tr>
<th>Project sites</th>
<th>Special Population Highest Emphasis</th>
<th>Special Population Lowest Emphasis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ilorin</td>
<td>Postpartum women</td>
<td>Newly married women wanting to delay their first child</td>
</tr>
<tr>
<td></td>
<td>Urban population</td>
<td>Single women</td>
</tr>
<tr>
<td>Ibadan</td>
<td>Urban population</td>
<td>Newly married women wanting to delay their first child</td>
</tr>
<tr>
<td></td>
<td>Postpartum women</td>
<td>Post abortion women</td>
</tr>
<tr>
<td>Abuja</td>
<td>Urban population</td>
<td>Newly married women wanting to delay their first child</td>
</tr>
<tr>
<td></td>
<td>HIV+ population</td>
<td>Poor population</td>
</tr>
<tr>
<td>Kaduna</td>
<td>Urban population</td>
<td>Poor population</td>
</tr>
<tr>
<td></td>
<td>HIV+ population/Postpartum women (tie)</td>
<td>Rural population</td>
</tr>
</tbody>
</table>

**Table 3. Respondents’ Ratings of Highest and Lowest Emphasized Populations in Family Planning Programs, 2011 FPE.**
Discussion

The FPE scores identify many areas that need improvement across the cities as well as areas where one city can learn from the others. Areas such as contraceptive security, including funding and access to a variety of family planning methods, enforcement of the legal age of marriage, and outspoken support from local and national leaders need improvement in all of the cities. Other areas, such as service and service related areas, Abuja, Ibadan, and Kaduna have the opportunity to learn from Ilorin, which received the highest scores for almost all of the questions.
References


